This information belongs to:_____ISP Start: _____ End: _____

Essential Information

Contact Information

Address:
PO Box:
City/Zip:
Home phone:
Cell phone:
Work phone:

Communication and Sensory Support

Describe how the individual communicates and the supports needed for communication (if any):

Primary language:

Could the individual benefit from a professional evaluation related to his or her sensory (including touch, sight, and hearing) or communication abilities? ☐ yes ☐ no If yes, address in the ISP

Health Information

Medication	Reason	Dosage	Route	Frequency	Physician	Location of side effects.
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

Medication and/or Food Allergies:
Date of last complete physical exam (within 1 year of start date):
Date of last dental exam:
Is there a history of substance abuse? ☐ yes ☐ no If yes, describe:
Are there any mental health support needs? ☐ yes ☐ no If yes, describe:

This information belongs to:_____ISP Start: _____ End: _____

Current Diagnostic Information and Medical Considerations

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Emergency Contacts/Representation

Name	Phone:	Fax:	Email:

Guardian:
Address:
AR:
Address:
Family #1:
Address:
Family #2:
Address:
Family #3:
Address:
Power of Attorney:
Address:
Emergency Contact:
Address:
Conservator:
Address:
Representative Payee:
Address:
Physician 1:
Address:
Physician 2:
Address:
Physician 3:
Address:
Dentist:
Address:
Other:
Address:
Other:
Address:
Other:
Address:

Support Coordination and Provider Contacts

Name	Phone:	Fax:	Email:

Support Coordinator/CSB:
DSS Eligibility Worker:
Sponsored Residential:
In-Home:
Group Home:
Employment:
Alternative to Employment:
Services Facilitator:
CD Employer:
Personal Assistance (Agency):
Companion (Agency):
Respite (Agency):
Skilled Nursing:
Fiscal Agent:
School:
After school care:
Childcare:
Other:
Other:

Summary of Health History

Describe all recent physical complaints/medical conditions, chronic conditions, restrictions on physical activities, past serious illnesses, serious injuries, and hospitalizations, sexual health & reproductive history (describe/list number of children, number of pregnancies, history of health problems/concerns related to the individual's sexual functioning [if any], impacts of medication on sexual functioning, an assessment of the individual's sexual functioning, individual's satisfaction with sexual functioning, the ability to have children, or the history of sexually communicable diseases are all possible components of this question), communicable diseases, current medical care needs, serious illnesses & chronic conditions of parents/siblings/significant others in household, current and past drug usage. Note if treatment has been provided.

Summary of Social/Developmental/Behavioral/Family History

Describe the individual's social, developmental, behavioral and family history.

This information belongs to:_____ISP Start: _____ End: _____

Summary of Employment and Educational Background

Education level: ☐None ☐Elementary ☐Middle School ☐High School ☐College degree
Employment status: ☐unemployed ☐part-time ☐full-time ☐other:_____

Describe employment and educational histories.

Ability to Access Services and Supports

Are there any concerns with this individual's ability to access services and/or supports?
☐ yes ☐ no
If yes, provide explanation:

Legal

Are there any legal issues? ☐ yes ☐ no If yes, describe:

Back-up Plan

Is a back-up plan required for this individual? (Required for Consumer Directed Services, Agency Directed Personal Assistance and Money Follows the Person) ☐ yes ☐ no
If yes, provide description of back-up plan and incorporate into ISP:

Exceptional Support Needs

Were any support needs identified on section 4 of the Supports Intensity Scale (SIS)? List below.

All items listed must have a response in the plan as a safety support.

Support Coordinator Signature: **Date:**

QIDP Co-signature: **Date:**